Fallon: Select Care

Coverage Period: 07/01/2015 - 06/30/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual and Individual + Family | **Plan Type: HMO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.fallonhealth.org/gic**. or by calling **1-866-344-4442**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$300 person/$900 family. Doesn't apply to preventive care.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For in-network providers $5,000 person / $10,000 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.fallonhealth.org/gic or call 1-866-344-4442 for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	Yes. Your PCP can provide you with a copy of the referral form when you need to see a specialist.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the section *Excluded Services & Other Covered Services.* See your policy or plan document for additional information about excluded services.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Not covered	----------None----------
	Specialist visit	Tier 1: $30 copay/visit; Tier 2: $60 copay/visit; Tier 3: $90 copay/visit	Not covered	Referral and preauthorization required for certain covered services.
	Other practitioner office visit	$20 copay/visit for chiropractic care	Not covered	Chiropractic care limited to 12 visits per year. Referral and preauthorization required for certain covered services.
	Preventive care/screening/immunization	No charge	Not covered	----------None----------
If you have a test	Diagnostic test (x-ray, blood work)	Deductible	Not covered	----------None----------
	Imaging (CT/PET scans, MRIs)	$100 copay/test then deductible	Not covered	Limited to one copay per day when performed at the same facility for the same diagnosis. Referral and preauthorization required for certain covered services.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.fallonhealth.org/gic.	Tier 1 plus Mail Order	$10 copay /prescription (retail and emergency); $25 copay/ prescription (mail order)	$10 copay/ prescription (emergency only)	Includes specialty drugs in this tier. Retail covers up to a 30-day supply; Emergency services covers up to a 14-day supply; Mail order covers up to a 90 day supply.
	Tier 2 plus Mail Order	$30 copay/ prescription (retail and emergency); $75 copay/ prescription (mail order)	$30 copay/ prescription (emergency only)	Includes specialty drugs in this tier. Retail covers up to a 30-day supply; Emergency services covers up to a 14-day supply; Mail order covers up to a 90 day supply.
	Tier 3 plus Mail Order	$65 copay/ prescription (retail and emergency); $165 copay/ prescription (mail order)	$65 copay/ prescription (emergency only)	Includes specialty drugs in this tier. Retail covers up to a 30-day supply; Emergency services covers up to a 14-day supply; Mail order covers up to a 90 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/surgery then deductible	Not covered	Up to four copayments per member per calendar year. Referral and preauthorization required for certain covered services.
	Physician/surgeon fees	Deductible	Not covered	Referral and preauthorization required for certain covered services.
If you need immediate medical attention	Emergency room services	$100 copay/visit then deductible	$100 copay/visit then deductible	----------None----------
	Emergency medical transportation	Deductible	Deductible	----------None----------
	Urgent care	$20 copay/visit	$20 copay/visit	Includes visits to contracted limited service clinics.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	Tier 1: $275 copay; Tier 2: $500 copay; Tier 3: $1,500 copay then deductible	Not covered	One copayment, per member, per quarter each calendar year. Referral and preauthorization required for certain covered services.
	Physician/surgeon fee	Deductible	Not covered	Referral and preauthorization required for certain covered services.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral Health Outpatient Services	$20 copay/visit	Not covered	Referral and preauthorization required for certain covered services.
	Mental/Behavioral Health Inpatient Services	No charge	Not covered	Referral and preauthorization required for certain covered services.
	Substance use disorder outpatient services	$20 co-pay/visit	Not covered	Referral and preauthorization required for certain covered services.
	Substance use disorder inpatient services	No charge	Not covered	Referral and preauthorization required for certain covered services.
If you are pregnant	Prenatal and postnatal care	Tier 1: $15 copay; Tier 2: $20 copay; Tier 3: $30 copay	Not covered	For prenatal care, you pay an office visit co-pay for your first visit only.
	Delivery and all inpatient services	Tier 1: $275 copay; Tier 2: $500 copay; Tier 3: $1,500 copay/admission then deductible	Not covered	One copayment, per member, per quarter each calendar year. Referral and preauthorization required for certain covered services.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible	Not covered	Referral and preauthorization required for certain covered services.
	Rehabilitation services	$20 copay/visit in an office	Not covered	Prior authorization required after 90 days for short-term physical and occupational therapy.
	Habilitation services	$20 copay/visit in an office	Not covered	Early intervention services covered for children from birth to age 3 with no copayment. Referral and preauthorization required for certain covered services.
	Skilled nursing care	Deductible	Not covered	Up to 100 days per year. Referral and preauthorization required for certain covered services.
	Durable medical equipment	20% coinsurance after deductible	Not covered	Referral and preauthorization required for certain covered services.
	Hospice service	No charge	Not covered	Referral and preauthorization required for certain covered services.
If your child needs dental or eye care	Eye exam	$20 copay/visit	Not covered	Routine eye exams are limited to one per 24 month period.
	Glasses	Not covered	Not covered	----------None----------
	Dental check up	Not covered	Not covered	----------None----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care

Excluded Services & Other Covered Services:

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care (limited to 12 visits per year)
- Hearing Aids
- Infertility Treatment
- Routine Eye Care (Adult)
- Weight Loss Programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-866-344-4442. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Fallon Community Health Plan, Member Appeals and Grievances Department, 10 Chestnut Street, Worcester, MA, 01608, 1-866-344-4442, ext. 69950, grievance@fchp.org. Additionally, a consumer assistance program can help file your appeal. Contact Health Care for All, 30 Winter St., Ste. 1004, Boston, MA, 02108, 1-800-272-4232, www.massconsumerassistance.org.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Language Access Services

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-344-4442.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $6900**
- **Patient pays $640**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Co-pays	$310
Co-insurance	$0
Limits or exclusions	$30
Total	**$640**

NOTE: These numbers assume the patient has not met any part of his/her calendar year deductible and is using in-network Tier 1 physicians and hospitals. If you go out of network, or see a Tier 2 or Tier 3 provider, your costs will be higher.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $4300**
- **Patient pays $1100**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$140
Co-pays	$920
Co-insurance	$0
Limits or exclusions	$40
Total	**$1100**

NOTE: These numbers assume the patient has not met any part of his/her calendar year deductible and is using in-network Tier 1 physicians and hospitals. If you go out of network, or see a Tier 2 or Tier 3 provider, your costs will be higher.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.